

**MAXIMUS FEDERAL SERVICES, INC.**

Independent Bill Review  
P.O. Box 138006  
Sacramento, CA 95813-8006  
Fax: (916) 605-4280

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12/6/2013

**Independent Bill Review Final Determination Upheld**

[REDACTED]  
[REDACTED]  
[REDACTED]

Re: Claim Number: [REDACTED]  
Claims Administrator name: [REDACTED]  
Date of Disputed Services: 3/19/2013 – 3/19/2013  
MAXIMUS IBR Case: CB13-0000324

Dear [REDACTED],

**Determination:**

A Request for Independent Bill Review (IBR) was assigned to MAXIMUS Federal Services on 8/26/2013, by the Administrative Director of the California Division of Workers' Compensation pursuant to California Labor Code section 4603.6. MAXIMUS Federal Services has determined that the **Claims Administrator's determination is upheld**. This determination finds that the Claims Administrator does not owe the Provider additional reimbursement.

**Pertinent Records and Other Appropriate Information Relevant to the Determination Reviewed:**

The following evidence was used to support the decision:

- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- Other: OMFS Outpatient Hospital Fee Schedule, National Correct Coding Initiative/Outpatient Code Editor Version 19.0 (1/1/2013-3/31/2013)

## Supporting Analysis:

The dispute regards the payment for surgical facility services on date of service 3/19/2013. The facility services were billed on a UB-04/CMS1450 using revenue codes for services and supplies related to a posterior spinal fusion. The Claims Administrator allowed reimbursement of \$8,083.22 for CPT 63047, 63048, 22612 and 72110. The Claims Administrator denied reimbursement for CPT 64722 indicating "Per CCI edits, the value of this procedure is included in the value of the comprehensive procedure." The Claims Administrator denied reimbursement on CPT 22842 and 20936 Modifier 59 indicating "Allowance for this inpatient service is not appropriate when supplied in an outpatient setting, unless pre-authorized by the insurer."

CPT 63047 - Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), [eq, spinal or lateral recess stenosis]), single vertebral segment; lumbar.

CPT 63048 - Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; each additional segment, cervical, thoracic, or lumbar (list separately in addition to code for primary procedure).

CPT 22612 - Arthrodesis, posterior or posterolateral technique, single level; lumbar (with lateral transverse technique, when performed).

CPT 64722 - Decompression; unspecified nerve(s) (specify)

CPT 22842 - Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (list separately in addition to code for primary procedure).

CPT 20936 - Autograft for spine surgery only (includes harvesting the graft); local (eg, ribs, spinous process, or laminar fragments) obtained from same incision (list separately in addition to code for primary procedure).

The provider is considered an ambulatory surgical center (ASC) and is located in Santa Barbara County. Based on the provider type, the reimbursement for services is calculated on the Centers for Medicare and Medicaid Services (CMS) Outpatient Prospective Payment System (OPPS). Procedures are assigned APC weights and "Proposed Payment Status Indicators." The billed CPT 64722 has an assigned indicator of "T". The "T" indicator definition is "Significant procedure, multiple procedure reduction applies" and qualifies for separate APC payment. The billed CPT codes 22842 and 20936 have an assigned indicator of "C". The "C" indicator definition is "Inpatient procedures, not paid under OPPS. Admit patient and bill as inpatient."

Based on a review of the multiple surgery guidelines and the National Correct Coding Initiative/Outpatient Code Editor Version 19.0 (1/1/2013-3/31/2013), the billed procedure 64722 is not generally reported with procedure code 63047. NCCI edits define when two procedure HCPCS/CPT codes may not be reported together except under special circumstances. If an edit allows use of NCCI-associated modifiers, the two procedure codes may be reported together when the two procedures are performed at different anatomic sites or different patient encounters. NCCI-associated modifiers may be utilized to allow payment of both codes of an edit. The documentation must support the use of the modifier. Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI edit include: Anatomic modifiers: E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI; Global surgery modifiers: 24, 25, 57, 58, 78, 79; other Modifiers: 27, 59, and 91. The billed procedure was not billed with any of the above Modifiers. The billed procedure code 64722 is an inherent part of the comprehensive code 63047. The Claims Administrator's denial of the billed procedure code 64722 was correct.

Per the OMFS Hospital Outpatient Departments and Ambulatory Surgical Center fee schedule, hospital outpatient departments and ambulatory surgical centers shall not be reimbursed for procedures on the inpatient only list, referenced in Section 9789.31(a), Addendum E, except that pre-authorized services rendered are payable at the pre-negotiated fee arrangement. The billed procedure codes 22842 and 20936 are on the inpatient only list and are assigned the "C" status indicator. The documentation submitted included an authorization from the Claims Administrator. The authorization was dated 12/11/2012 and authorized the procedure "Posterior spinal fusions L4-5 with posterior lumbar inter body fusion" at a PPO Hospital (inpatient only). The disputed codes 22842 and 20936 were not authorized as an outpatient procedure. The denial of the billed procedure codes by the Claims Administrator was correct.

There is no additional reimbursement warranted for Official Medical Fee Schedule codes 64722, 22842 and 20936.

The chart below provides a comparison of billed charges and reimbursement rates for the codes and dates of services at issue.

Validated Code	Validated Modifier	Validated Units	Dispute Amount	Total Fee Schedule Allowance	Provider Paid Amount	Allowed Recommended Reimbursement	Fee Schedule Utilized
22842		1	\$9685.71	\$0.00	\$0.00	\$0.00	OMFS
20936	59	1	\$9685.71	\$0.00	\$0.00	\$0.00	OMFS
64722		1	\$9685.71	\$0.00	\$0.00	\$0.00	OMFS

**Chief Coding Specialist Decision Rationale:**

This decision was based on OMFS Inpatient Hospital fee schedule and comparison with explanation of review (EOR). This was determined correctly by the Claims Administrator and the payment of \$0.00 is upheld.

This decision constitutes the final determination of the Division of Workers' Compensation Administrative Director, is binding on all parties, and is not subject to further appeal except as specified in Labor Code section 4603.6(f)

Sincerely,

[REDACTED], RHIT

Copy to:

[REDACTED]  
[REDACTED]  
[REDACTED]

Copy to:

[REDACTED]  
[REDACTED] [REDACTED]  
[REDACTED]